Chapter 9

Clinical Documentation

Constance J. Dalenberg and Linda Brown

Introduction

The clinical professional must keep a record to document the treatment of a child crime victim. Such a record helps to ensure proper treatment procedures and serves as evidence of the quality of treatment. The treatment record serves a number of purposes for the client, the individual provider, and the Victims of Crime program (VOC). These include:

- Refreshing the therapist's memory about important aspects of treatment, particularly if treatment occurs over several years or is interrupted for periods of time.
- Ensuring continuity of care in the event of the unavailability of the provider.
- Allowing evaluation of treatment for the purpose of reimbursement.
- Assessing the necessity of continuation of treatment.
- Providing a source of outcome data for patients. While most therapists are not also conducting research, records allow therapists to self-evaluate over time, comparing the progress of the case to other cases with like characteristics and learning information that is of value to future patients, such as the likely length of treatment.
- Providing crucial data in a patient's legal action against the perpetrator of a crime.

All records should be created with the above purposes in mind. For instance, the practitioner may believe that potential legal action is not relevant because parents or other adults have decided not to press for legal remedies. However, children have the legal right to sue when they reach the age of majority (and for three years thereafter), a fact that also bears upon the issue of retention of records (see below).

In the initial stages of therapy, one often does not know whether treatment may be interrupted, either by the client or the therapist. Regardless of the initial situation, legal proceedings and considerations can change. Since it is difficult to predict when one's records might be accessed, it is always prudent to prepare for the widest range of possibilities.

Informed Consent

The provider should develop an **informed consent process** for the parent or guardian, and an **informed assent process** for the child, that clearly and fairly describe the parameters of treatment.

The use of a written informed consent document is strongly recommended, with the understanding that informed consent is a dynamic rather than static part of treatment (Gutheil, Bursztajn, & Brodsky, 1984; Gutheil, 1993). Ideally, the professional engages in consent procedures throughout treatment, especially at times when outside disclosure becomes necessary or when the patient's needs change. In order to protect client rights and to facilitate and enhance the effectiveness of treatment, some form of consent procedure should take place at the beginning of treatment (Sullivan et al., 1993; Kaplan, 2000). Informed consent can also be used as a direct intervention, helping to move clients and their families into roles that can best serve treatment goals. Golub (1989) writes that "a comprehensive process of informed consent leads to the development of the therapeutic alliance," resulting in a sense of "safety and trust" in the relationship (p. 11).

Informed consent is a relatively new doctrine in medicine and psychotherapy. It entered American case law in the mid-1950s and was clarified in the 1972 *Canterbury v. Spence* decision (Simon & Sadoff, 1992). While informed consent is now an accepted fact of treatment for nonpsychiatric medical treatment, the majority of psychotherapists do not give written informed consent to their clients except in areas regarding confidentiality and fee agreements (Handelsman et al., 1986; Stein, 1995). In the Stein study, therapists were more unlikely to give comprehensive informed consent to clients with greater pathology. However, the evolution of ethical standards, new guidelines from major mental health organizations, and the increasing threat of litigation have convinced the majority of practitioners that some change is necessary (Stein, 1995). The major obstacle to change is uncertainty regarding what information should be included in the consent, and how consent should be worded (Handelsman et al., 1986; Stein, 1995).

Informed Consent

Form 1 lists the important informed consent issues to be addressed with a psychotherapy patient and — in the case of a child — the patient's parent or guardian. Samples of informed consent documents are contained in many handbooks (Freedheim & Shapiro, 1999; Moline et al., 1998; Wiger, 1999; Zuckerman, 1999). In an alternative approach, the therapist provides a list of suggested questions to the patient, and allows the patient to decide which questions to ask, when to ask them, and the level of detail they desire. Form 1 includes such a list and can be offered to the client. The clinician then documents in treatment notes which questions the client asked and what information was given, and gives specific handouts to the client at their request. Form 2 is an example of a handout on confidentiality. Another alternative format for client-directed informed consent is provided in Handelsman and Galvin (1988).

Informed Assent

Although a parent has legal authority to consent to a child's treatment, ethical guidelines universally hold that the child client, regardless of age, should have substantial rights in the treatment process. This issue also is relevant to treatment effectiveness, since therapy that is perceived as imposed behavioral correction is unlikely to be useful to the child. To prevent real or perceived betrayals, the therapist is advised to discuss the limitations of confidentiality with the child. The assent process should clarify the role of the child in therapy and clarify the child's rights. Sample assents can be found in many child psychotherapy textbooks or in sourcebooks for clinical documentation (Freedheim & Shapiro, 1999; Wiger, 1999). A sample of an informed assent interview with a child is given in Fox (1997).

The complex issues of confidentiality with child clients also require that the clinician's policy must be made clear at the beginning of treatment. Attorney and psychologist Bryant Welch (1999) suggests that psychotherapists work out a written agreement with the child and the parents or guardian on the subject of confidentiality before therapy begins. In order for therapy to be successful, this agreement should emphasize the need for privacy, particularly when working with adolescents.

Treatment Records

The treatment record should include the following:

- Informed consent and assent
- Initial history
- Results of the psychological assessment of the child
- Documentation of collateral interviews
- All materials received from outside sources regarding the child
- Relevant release forms
- Treatment notes
- Billing records

Requirements for the contents of treatment records differ among professional organizations. Readers should check the ethical mandates for their organizations. In general, a record that contains the information listed above meets California legal requirements and the ethical requirements for most organizations. The contents of treatment notes taken are covered in greater detail below. Notes and billing information may be recorded in any medium (for example, handwritten, typed, or computerized) as long as care is taken to ensure that the form of record-keeping preserves the confidentiality and security of the information. For example, records should not be kept in locations to which clients or others might have access, such as computers without password protection.

Computerized Records

There is no prohibition against keeping records on a computer. However, the practitioner should be aware that this convenience comes with a cost. If another practitioner needs the records, it is not an acceptable legal or ethical excuse to claim that the computer was stolen or damaged. It is best practice to make backup copies of all computer files on a regular basis. Copies should be kept in a secure location.

Intake Information

Many clients are in crisis when they enter psychotherapy, so the therapist may not take time to record all relevant intake information. It is useful to have a written intake form that can be given to the parent or guardian for completion at some convenient time early in treatment. If the parent is unavailable, foster parents may be asked to complete the form and to request any information that they do not know from the Child Welfare Worker (CWW). Such a form can reveal information that is critical to the child's health. Form 3 shows a list of relevant issues. The Referral and Intake chapter offers further information on the intake process.

Releases

It is good practice to obtain release forms for any discussion of clinical information with any source, even if the practitioner believes that the patient should know that information will be released (for example, to the court, to attorneys, or to a case coordinator). Form 4 shows a release form that can be used as a template for the clinician. Copies of all such releases should be kept in the treatment file.

Crime-Related Information

While note-taking practices vary widely (see below), and some latitude in form of notes can be tolerated, the statements of a child which are directly relevant to a crime fall into a special category. The clinician is not likely to recall a child's admissions and accusations verbatim, months and years after the session in which they were offered (such as at trial). If the therapist fails to document a child's statements explicitly, the therapist's memory will certainly be called into question. Therefore, we recommend the following guideline:

Treatment notes should include verbatim statements of any disclosures of crimes against children. They should also document anything disclosed by a patient that puts a child at risk for harm. Clinicians should not feel obligated to log every statement made by a child about an offender. It is more effective to use one or more forms that remind clinicians of the crucial questions related to child crime (see Form 5). For example, Form 5 (which was adapted from Trauma Research Institute Form 51) includes information on the perpetrator's perceived motives and the child's potential provocations. While this information may seem to be of greater clinical than legal importance, the therapist should know that some criminal charges stand or fall on the proof of intent to injure. Furthermore, current California law defines child abuse in part by the "justifiability" or perceived "cruelty" of the acts. The child's prior behavior may be a critical factor. For example, was an injury accidentally caused when a parent attempted to calm or restrain an out-of-control child, or was the injury an outcome of the parent's loss of control?

A child's remarks about the connection between a crime and their psychological and physical state are also crime-related statements. Legally, if a child sues for damages, the attorneys must offer evidence not only of

the child's psychological disturbances, but also the link between these problems and the crime. This is a difficult task, because there are often multiple plausible causes of distress in the life of a traumatized child. Clear statements by the child linking their symptoms to the crime (for example, "I am afraid to go to school because there might be more bad men there," or "I cry when I think about [the crime]") can be the most definitive evidence establishing the symptom-crime relationship.

Psychological Assessment

This task force recommends the professional use of objective documentation of the child's initial symptoms and continuing improvement (or lack of improvement). In complex cases, this may involve a full psychological evaluation. In other cases, it would involve use of a short battery of self-report and parent/therapist report instruments (see the "Assessment" chapter). The latter tests typically may be purchased for a few dollars per copy and may be used by professionals with a Bachelor's degree in psychology, counseling, or a closely related field, if the individual has received training or coursework in assessment at an accredited college or university.

Termination

At termination, a treatment summary is valuable to the clinician and to the client. It can also be valuable if further therapy is needed at some future time. If the client terminates therapy prematurely, the therapist should document that the client has been told that additional treatment was needed, and that other treatment options were presented.

Note-Taking Guidelines and Strategies

Ethics guidelines do not dictate the style of note-taking for the individual practitioner. However, a formal note-taking strategy can be helpful for clinicians. Using dated treatment notes, the provider should track changes in the identified problems, symptoms, beliefs or behavior in the child, in order to assess the effectiveness of treatment on an ongoing basis and consider refinements or new treatment directions.

Treatment notes can assist the clinician by providing self-reminders about the progress of the child in therapy. The **SOAP** note is one such tool. This format uses four types of information sources:

- **S**ubjective data describes the client's subjective reports. This data may be in the form of quotes, such as "I just wish I could kill that person" or "Sometimes I am really scared of my mom." Documentation of the child's own words can be valuable both clinically and legally.

- **O**bjective data describes the presence or absence of objective evidence for the client's subjective state (depression, anxiety, and so on)? What is the child's appearance? What are the content, rhythm and rate of speech? How engaged is the child in the therapy?

- **A**ssessment records the therapist's interpretation and assessment of the subjective and objective data. This does not have to be a formal diagnostic statement but instead might be an ongoing and flexible evaluation of the child's progress.

- **P**lan describes what the therapist intends to do in response to the assessment. This may include changes in therapy modality, referrals to other professionals, further data gathering, hospitalization or safety plans, or ongoing contracts with the child.

An example of a SOAP note for a child assaulted by a bus driver might be:

S: "I'm too scared to go on the bus anymore"

O: Foster mother reports child's resistance or refusal to take any public transportation. David is avoidant of the subject of the assault, and hid one of the toy buses in the toy car set in during therapy.

A: Still showing avoidant symptoms. Possible PTSD.

P: Work on controlled exposure to trauma symbols through games in session. Develop controlled exposure plan for use at home.

When used in practice, a formal note-taking style may tend to encourage repetition and redundancy. However, their value as a treatment tool lies in reminding the therapist to relate symptoms to assessment, and assessment to planning. As the clinician becomes accustomed to a formal style of note-taking, treatment sessions often take on more structure. The formalized approach also saves time, since clinicians do not have to write a complex analysis of the process and flow of each session.

To complement a formalized note-taking strategy, it is useful to employ a Significant Incident Form (see Form 6). This form does not need to be used regularly, but it can be helpful when the clinician determines that an intra-session or extratherapeutic event should be discussed in greater detail. The treatment record can also include a Crisis Form (see Form 7) where the clinician documents the specific actions taken to address a perceived crisis. Future treatment providers can use this record to determine which strategies were effective and which were not.

The therapist does not have to use a formal note-taking style. The practitioner may desire more freedom to include editorial and theoretical comments. However, there are types of content that should not appear in a treatment record:

- **Therapist's subjective feelings** — The main purpose of treatment notes is to allow future readers to determine the history of the child's symptoms and problematic behaviors and to document the specific techniques that were most helpful for a given problem. While the therapist's counter-transference feelings are critical information for the treating professional (Dalenberg, 2000), disclosure of the therapist's personal feelings toward the patient is risky behavior. Some commentators (Welch, 1999) go so far as to say that therapists "should never discuss their own countertransference experiences — the feelings and fantasies that they have toward their patients — in the clinical record" (p. 2). Practitioners should ask themselves whether the notes will be useful to the next treating professional, and focus on content that is of practical utility within the patient's record. To the degree that the therapist's feelings bear upon clinical questions (for example, "I feel as if I am pulled into a battle with Susan whenever I raise the issue of her school performance"), the therapist can choose to focus on the client's behavior ("Susan withdraws or becomes belligerent when issues of school performance arise.")

- **Details of an adult or child's fantasy life or hyperbolic statements about their relatives, parents, or friends** — This type of information may only prove embarrassing and could even endanger a patient in a vulnerable situation. Except where it relates directly to a child safety issue, specific information about the child's (or parent's) life, rather than about symptom progression, does not have to be included.

- **"Process" or "personal" notes** — Process notes relate to the dynamics of treatment, while progress notes relate to symptom changes. Regardless of how the therapist classifies these notes, they are all discoverable during litigation. All notes should be written with the expectation that they may eventually be read by the client, the client's family, or the legal system.

Alteration and Destruction of Records

Record retention laws and regulations vary greatly, as do the ethical guidelines within various specialties. It is the responsibility of the practitioner to be aware of the latest guidelines for such retention and the state laws that apply to record retention. A good source for this subject (and other legal questions) is the periodically updated California Laws for Psychotherapists (Conidaris & Erikson, 1999). Since January, 1995, the California Health and Safety Code requires practitioners to maintain patient records for a minimum of seven (7) years and until one year after a minor has reached the age of 18. In the absence of other requirements, complete records should be maintained for any child client until three (3) years after the age of majority. After this period of time, it is acceptable to maintain a case summary only.

Clinicians also should be aware of the legal significance of alteration of records. If changes are made in a chart that has already been typed or handwritten, the material should be crossed out rather than erased, so it is clear that the alterations are not being concealed. A footnote or reference to another note can explain the change. For example, if the clinician notices a mistranscription, or finds an inaccuracy that is due to a clinician or typist mistake, it is legitimate (and good practice) to correct the record. If the need for the change is due to the clinician changing his or her mind about an issue, it is better practice to simply note how and why the older information is inaccurate. For example, "On 6.10.99, I noted that Chris has missed a good deal of school due to illness, based on the child's report. However, his school record shows that he missed only 3 days this year."

While the above review is meant to be a summary, the clinician should note that the rules governing recordkeeping (including minimalist records, destruction of records, and release of client information) are multi-determined by a complex set of laws, regulations, and ethics codes. In addition, the individual institution in which the therapist may be practicing may have its own record-keeping requirements. Good records are always reasonably current, secure from inappropriate access, objective, and comprehensible to another trained professional. Problems in any of these areas create difficulties for the treating clinician.

References

Conidaris, M., & Erikson, J. (1999). *California laws for psychotherapists.* Gardena, CA: Law Distributors.

Dalenberg, C. (2000). *Countertransference and the treatment of trauma.* Washington, DC: American Psychological Association Press.

Faden, R., Beauchamp, T., & King, N. (1986). *A history and theory of informed consent.* New York: Oxford.

Fox, L. (1997). The reality of using informed consent "kid style." *International Journal of Reality Therapy, 17,* 60–62.

Freedheim, D., & Shapiro, J. (1999). *The clinical child documentation sourcebook: A comprehensive collection of forms and guidelines for efficient record-keeping in child mental health.* New York: John Wiley.

Golub, M. (1989). Informed consent and the establishment of the therapeutic sanctuary. *The California Psychologist, 23,* 11–12.

Gutheil, T. (1993). Informed consent in therapy. *Hospital and Community Psychiatry, 44,* 1005.

Gutheil, T., Bursztajn, H., & Brodsky, A. (1984). Malpractice prevention through the sharing of uncertainty: Informed consent and the therapeutic alliance. *New England Journal of Medicine, 311,* 49–51.

Handelsman, M., & Galvin, M. (1988). Facilitating informed consent for outpatient psychotherapy: A suggested written format. *Professional Psychology: Research and Practice, 19,* 223–225.

Handelsman, M., Kemper, M, Kesson-Craig, P., McLain, J., et al. (1986). Use, content, and readability of written informed consent forms for treatment. *Professional Psychology: Research and Practice, 17,* 514–518.

Kaplan, D. (2000). Using an informed consent brochure to help establish a solid therapeutic relationship. In Watts, R. (Ed.). *Techniques in marriage and family counseling. Vol. 1. The family psychology and counseling series.* (pp. 3–10). Alexandria, VA: American Counseling Association.

Moline, M., Williams, G., & Austin, K. (1998). *Documenting psychotherapy: Essentials for mental health practitioners.* Thousand Oaks, CA: Sage.

Simon, R., & Sadoff, R. (1992). *Psychiatric malpractice: Cases and comments for clinicians.* Washington, DC: American Psychiatric Press.

Stein, E. (1995). *The effect of ethical and legal presentations upon therapist's attitudes and projected practices of informed consent in clinical treatment.* Unpublished doctoral dissertation, California School of Professional Psychology, San Diego.

Sullivan, T., Martin, W., & Handelsman, M. (1993). Practical benefits of an informed-consent procedure: An empirical investigation. *Professional Psychology: Research and Practice, 24,* 160–163.

Welch, B. (1999). The hazards of working with children and adolescents. *Insight: Safeguarding psychologists against liability risks.* Amityville, NY: American Professional Agency.

Welch, B. (1999). Walking the documentation tightrope. *Insight: Safeguarding psychologists against liability risks.* Amityville, NY: American Professional Agency.

Wiger, D. (1999). *The clinical documentation sourcebook: A comprehensive collection of mental health practice forms, handouts, and records.* New York: John Wiley.

Zuckerman, E. (1997). *The paper office: Forms, guidelines, and resources.* New York: Guilford.

Form 1. Informed consent issues.

Questions patients often have for their therapists early in therapy:

What is your training?

Are you licensed or registered as a therapist?

How do I reach you?

What should I do if I have an emergency?

What is your financial policy, including fees and cancellation policy?

What will happen in our sessions?

How does your type of therapy work to help people with my problems or issues? (or my child's problems or issues)

What are the alternatives to the type of therapy you offer?

What are the benefits and risks or choosing this type of therapy?

What do I do if a session feels unpleasant or harmful in some way?

Confidentiality rules and release requests:

What kind of records do you keep? (You might want to share any concerns about specific information that you consider very private.)

Will you terminate therapy with me for any reason without my asking for it?

Should I take any psychological tests? Why would they help?

Do you have consultants or supervisors that you talk to? Who are they?

Some patients also wish to know:

What is your experience in treating *x* (some important problem for you)?

Are you trained in *x* (some particular skill, such as hypnosis or biofeedback)?

How long does it usually take to address *x* (some important problem for you)?

Form 2. Confidentiality Description (Trauma Research Institute)

You are probably familiar in general with the fact that I promise as your therapist not to reveal your secrets (or even general information that you do not regard as secret) to anyone. Even if you want me to talk to give information about you to someone (another doctor, for instance), I will ask you to sign a form that puts in writing what type of information I can and cannot share. In this way I ensure that I do not misunderstand the limits of what you want to share, and you can ensure that you remain in charge of these disclosures.

You may be less aware of the legal exceptions that would force me to disclose some specific fact. They are the following:

- If you or your child tells me about a plan to hurt someone physically, and the threat seems real to me, I am required by law to try to protect the person being threatened by warning them or calling law enforcement.
- If you or your child is suicidal, and you and I are convinced that these impulses cannot be controlled, I am required to try to prevent self-injury, which may mean informing someone in your family or arranging a hospital stay.
- If there is evidence that would lead me to have "reasonable suspicion" that an adult is now abusing a child or an older person, I am required to report this information so that others might investigate it.
- If therapy or testing is by order of the court, I will typically be required to reveal what you tell me to the court, including results of the testing. In these cases we can get very specific about what needs to be told.
- If an outside agency or company is paying for your treatment, this agency may require knowledge of your diagnosis and periodic updates regarding how you are doing. You can tell me not to disclose this information, and I will follow your instructions, but some agencies then will refuse to pay.
- Finally, if you sue anyone for something, and claim that you or your child has been damaged psychologically (for instance, if you have a stress claim or a trauma claim after an accident or assault), then you may be required to give the attorneys on both sides access to my records. They will want to compare your symptoms at that time to your symptoms when you saw me, to assess the truth of your claim to damages.

In addition to these legal exceptions, I sometimes talk about my cases to respected colleagues who also have a mandate to keep information confidential. If you are taking a medication, for instance, I might talk to a physician (without disclosing any information about you) to find out if this medication has any effects on your mood that I need to know. I will never give any identifying information out about you to anyone in these discussions without your permission.

Form 3. Issues to Cover in Initial Assessment

Client contact information.

Parent or guardian's view of child's presenting problems.

History of child's presenting problems.

Nature of crime in which the child was victimized.

Any other significant traumatic events in the child's life.

Child's medical history: previous serious illnesses, any current medication.

Current family structure.

Is there any significant family history of serious psychiatric or medical nonpsychiatric problems?

What is the child's social structure? How many close friends does he or she have?

How does the child use his or her leisure time?

How is the child doing in school, both socially and academically?

What does the parent or guardian see as the child's greatest strengths?

Has the child had any previous treatment or therapy?

How much time does each parent or guardian spend with the child? Doing what?

What is the extent of each parent or guardian's use of alcohol or drugs?

Have there been any recent traumatic events in the life of the parent or guardian?

Do parents or guardians currently have any major medical or psychiatric problems?

Form 4. Sample Release of Information

Professional's name and address
Professional's phone or fax number

Authorization for Release of Information to *[Insert Professional's Name]*

Regarding: _____ Date: _____
[fill in client's name]

To: *[Insert Professional's name]*

I, _____, hereby consent and authorize you to release specified information
[client will sign here]

concerning the above named individual to:

Professional's name
Professional's address and contact information

The information shall include:

_____

_____

_____

[Optional expiration clause]: I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This informed consent for the release of information will automatically expire on: _____.

I hereby release *[Insert Professional's name]* from all legal responsibility that may arise from the release of the above requested information. This authorization is fully understood and it is made willingly and with informed consent on my part.

_____ _____
Signature *[Client signs here]* Date

Form 5. Sample form for recording verbatim crime-related statements

Verbatim Crime-Related Statements

Client _____ Date _____

1. Statements related to describing exact nature of the crime. *[Who did what to whom with what result]*

2. Statements related to possible sources of evidence for the crime. *[Possible witnesses, descriptions of weapons, descriptions of crime scene, descriptions of perpetrator.]*

3. Statements related to perceived motives of offender for engaging in crime. *[Intentionality, relationship to mental illness, repetition of statements made by perpetrator.]*

4. Statements related to child's perceptions of his/her own provocations or behavior immediately preceding the crime.

5. Statements made by the child regarding the link between the crime and the child's current psychological or physical state.

Form 6. Sample Significant Incident Record

Significant incident record: Date _____

Significant incidents are extratherapeutic or therapeutic events which are not part of the expected course of therapy, and necessitated change in treatment approach, special intervention, or consultation.

Form 7. Sample Crisis Form

Interventions taken: See Crisis or Significant Incident Record # _____

_____ Consultation with _____ Date _____

Suggestions:

_____ Medication change or referral

_____ Change in session timing or length

_____ Change in availability

_____ Change in pace or depth of therapy

_____ Increased supportive v. expressive interventions

_____ Target the following crisis-related thoughts:

_____ Reinforce areas of strength:

_____ Suggested additional sources of support:

_____ Suggested changes in self-care

_____ Discussed alternative care (e.g., hospitalization)

_____ Contracted with patient

_____ Other: